Missouri MRDD Home & Community Based Services Organizational Review

A review of the 11 Regional Centers and a sample of providers and families in each area, conducted in May 2006

August 17th, 2006

INTRODUCTION

This report summarizes key findings from a broad review of Missouri MRDD's home and community based services. The review was conducted by 3 teams, which between them spent 3-4 days in May 2006 in each of Missouri's 11 MRDD Regional Center areas – in each area interviewing consumers, families, provider staff and DMH staff.

In all, there were 41 reviewers contributing their time to this project, including:

- 13 Provider staff;
- 10 Family/advocates;
- 6 Regional Center Directors;
- 6 State QA Team (MRDD) staff;
- 4 Division staff; and
- 2 DMH staff

Between them they interviewed: Various levels of staff at each of the 11 Regional Centers; over 60 provider sites (including large and small providers, providers covering a spectrum of rates for services, accredited and certified providers, and a variety of services – in each area); and over 100 consumers, family members and advocates. The teams accommodated specific meetings when these were requested and accepted written feedback when offered, including several anonymous written reports.

The interviews were semi-structured, following a predefined script of open ended questions tailored for each interview category and encouraging a broad conversation regarding the strengths and weaknesses of all areas of the Division's operations.

All of the teams reported that very open and often frank discussions resulted in every area visited. Each team compiled a brief 3-5 page synopsis of findings for each regional area.

This report, in turn, is a synthesis of those 11 regional reports and highlights the themes that emerged with a high degree of consistency from interview subjects within each region and across the state. Despite the high degree of congruence in the findings, it should be noted that exceptions can be made to most of those findings -- they are general and overall conclusions that apply in most but not every specific individual case.

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STRENGTHS OF THE REGIONAL CENTER SYSTEM

There are many good things going on around the state but the reviews found the system is stretched. Many leaders, staff, providers, consumers and families identified committed and dedicated staff overall. In every area, there is a core group of staff with longevity and experience. We heard numerous comments about staff working as a team, both from providers and regional centers, yet not always between the two. Staff expressed support from their peers, willing to step up and help each other. There were areas in which creativity in staff deployment was recognized-- weighted case loads, business office working with provider on budget, use of intake team, redirecting positions to allow more flexibility, to mention a few examples. Overall, regional centers were described as a resource to the local area with staff knowledgeable about resources, community and culture.

OPPORTUNITIES FOR IMPROVEMENT

The various interviews and reviews highlighted a number of issues of concern that were consistently reported around the state. This report categorizes these issues as falling under the broad headings of "Leadership and Culture", "Services and Access", and "Staffing and Resources" and presents them all as opportunities for improvement.

Leadership and Culture

<u>Philosophy, Vision, Mission</u>

The most frequently and emphatically voiced concern throughout this review was the general observation of a complete "pendulum swing" away from person centered and habilitation towards mere compliance with health and safety directives – when what our consumers need from us is a more consistent sense of balance of all of the above.

This shift in priorities conflicts with the previously understood mission, but is not a deliberate restatement of the mission so much as a conflict between a reactive management style and the stated mission. The process goes something like this:

- Something bad happens somewhere and the reaction is to over-generalize from the specific problem and impose new requirements everywhere, somewhat indiscriminately. (The "water temps" scenario was typically referenced as only the most recent of a more general and long standing phenomenon.)
- The new requirements then tend to be implemented with insufficient forethought and lend to inconsistent practice between regions, and often even within a region.
- There are many issues that are top priorities but only for the day – we don't seem to operate in terms of systems and processes supporting long term priorities.
- This results in too many requirements in the sense that there are more than we have the capacity to enforce on providers or providers can enforce on themselves – this in turn adds to the "gotcha" nature of the Quality Assurance concerns below.

A related concern raised in a variety of contexts was a general lack of clarity in roles and expectations: What is the role of the Regional Center, what do we really expect of a provider, what are the respective roles of various Regional Center staff, what is the role of Central Office? These uncertainties combine with the reactive posture of management and translate directly into fear for both Regional Center and provider staff. All levels of staff report needing permission for just about anything, just to be safe, and many staff (provider and DMH) report working in ongoing fear of losing their jobs or possibly their careers to any misstep within a complex system of rules they don't completely understand. This in turn leads into defensive behaviors that further undermine our mission.

There is a consistently different perception of the respective authority between Regional Centers and providers – each sees the other as too powerful. Providers report that part of their fear is of getting a "bad reputation" (by complaining, for example) and that word of mouth at the Regional Center translates into empty beds and lost revenue, and that this "punishment" isn't based on objective standards. Conversely, Regional Centers report that it is too hard to implement corrective actions (up to closing in extreme cases) at any well connected provider, thus confounding their oversight of services in the region.

One observation, variously repeated, summarizing all of this was that we need to move beyond a narrow focus on compliance with directives to more of a focus on what positive actions lead to the outcomes we desire for our consumers, and be guided more by an assessment of those outcomes than by a reaction to isolated failures. The latter must be addressed, but leadership demands a broader vision than avoiding failure.

Quality Assurance System

The Quality Assurance (QA) system is seen by providers as intrusive and ineffective, and by various Regional Center staff as inefficient and time consuming. There are various features that contribute to these views:

- The larger providers typically have extensive "in-house" QA processes. These are required, for example, when a provider is accredited. MRDD's QA system interfaces poorly, if at all, with these systems leading to many duplicated efforts.
- Within the MRDD QA system, there are various overlaps between RN, QA, and service monitoring roles.
- There is considerable variation from service coordinator to service coordinator as to what is covered by service monitoring and different interpretations when covering the same thing. This is especially obvious and frustrating to the many providers with multiple service coordinators, often in the same home. Providers report a very different experience of the QA process, largely depending on the experience and competence of their service coordinators.
- There can be different interpretations of Division Directive requirements between categories of staff within the Regional Center, and different understandings of requirements between providers (looking at contracts and regulations) and the

Regional Center (looking at Directives). This also translates into an inconsistent interface between License and Certification reviews and MRDD QA.

- Due to the increasing demands of the monitoring systems combined with growing caseloads, there is less and less time available for quality enhancement type activity
    - Service Coordinators, QA staff, & providers agree on this as a need
    - No one is digging for "root causes" of problems
    - We need more training on systems, process improvement orientation versus finding fault and blame
- There appears to be no way for providers to correct errors in tracking systems
- Regional Center staff report that the QA Plans they require (for corrective actions at a provider) often do not lead to the desired result and this appears to typically have no consequence. Conversely, providers report a lack of objective standards as to when an issue is a problem requiring correction.

All of which adds directly to the fears present at the various levels of the system and translates into what is perceived, by both provider and Regional Center staff, as a "gotcha" oriented QA system. That word and "CYA" were frequently used by interviewees throughout discussions of the QA system.

The MRDD QA system has an almost exclusive focus on *provider* compliance. The system does not result in feedback to management regarding the compliance or enhancement of MRDD's internal processes, which are viewed by the providers as often larger concerns than – or in exceptional cases even the root causes of -- the issues the system cites as provider deficiencies.

<u>Abuse & Neglect Reporting and Investigation</u>

The universal concern raised regarding the Abuse/Neglect (A/N) process was the timeliness of investigations, which were reported as often stretching into months in duration, with staff on leave in the meantime and (possibly innocent staff) quitting for work elsewhere. (See Appendix 2)

Another concern often cited was for the scope of what is classified as neglect – this issue was raised more frequently by providers than by DMH staff, but the provider consensus seems to be that some of the "Neglect 2" classifications could be dealt with more effectively as supervisory issues. Since that is the broadest category of allegations this could also free resources to allow for more timely review of the more serious allegations.

Another timeliness issue raised was the initial reporting of events to the regional centers. The general consensus was that the more serious events do get reported but not always within the expected 24 hour standard. Concerns about under reporting were raised specifically regarding minor incidents of less than abuse or neglect priority. The latter issue was clearly identified as provider specific in that many providers in each region routinely report the minor events and some do not.

Outside of the timelines issue, there was general support for the centralization of investigations and (with occasional exception) support regarding the quality of investigations themselves. One centralization related observation made in several locations was that the Regional Center Director is no longer effectively the determiner, but is potentially still required to testify as if that were still the case. The comments were to let them be determiners or admit they are not -- either way would be preferable.

Effects of Consolidation

The consolidation of the Regional Centers was consistently reported as a resource driven decision that has diluted the leadership in each region, slowed decision making, and impaired communications at the local level. With that said, everyone also reported coping with the situation, just that it was not ideal and that the Regional Center Director position, in particular, is a full time job.

Communication

Providers and Regional Center staff alike report that providers often know issues, changes, and announcements from Central Office before the Regional Centers are informed. This makes our own staff appear ill informed. Similarly, the broad consensus from the field is that Central Office is insufficiently aware of local problems or dismissive of the magnitude of them. The most frequently referenced example of this was the local costs of last minute information requests from Central Office. In either case, the larger communications disconnect appears to be between Central Office and the Regional Center, not within the region.

Services and Access

Gaps

There is consistency across the state identifying several service gaps. These gaps include:

- crisis intervention and support/crisis teams,
- respite, especially in-home respite,
- services for the co-occurring MR/MI population,
- placements for the forensic population, especially sexual offenders,
- dental services,
- transportation,
- services to address behavioral challenges,
- more support for families with an adult with special needs in their home;
- autism services; and
- transition from children's services to adult.

Although these are state-wide issues, there were additional needs for services identified for specific regional center service areas, such as services for the deaf and visually impaired in the southwest and need for First Steps therapists in the north/northeast.

Relationships with psychiatric services providers

The need for cooperation and collaboration internally with the Division of Comprehensive Psychiatric Services was identified, as well as the same need for cooperation, collaboration and services with community mental health centers. There is a perception that, once an individual is known to have an MR/DD diagnosis, psychiatric providers step out of the picture and give the entire responsibility to MRDD. (It is noted that there is a similar perception on the psychiatric side—once an MI diagnosis is made, MRDD wants to step away.) There has been an increase in behavior challenges with the MRDD population, whether or not an MI diagnosis has been made. In many areas of the state, psychiatrist services are difficult to access and, if one can get an appointment, the individual may have to travel long distances to be seen. There is often a six-week or more wait to be seen. When a crisis occurs for a person with MR/MI that might require hospitalization, it is very difficult to find a facility that will admit and it's perceived that the habilitation centers are "closed" to admissions so service coordinators feel blocked from resources within MRDD as well. One regional center director expressed that there was much better problem-solving for admission and crisis issues when DMH had mental health coordinators; there is little help from administrative agent in that region. There were some comments about wanting opportunities for MRDD and CPS to learn from each other and share expertise. Staff and providers find it difficult to know and provide the necessary supports for those with mental illness, with forensic background and especially finding placement and supports for sexual offenders. They would like to see the CPS system as a resource to consult, build and learn the supports in the community. It deserves a mention that at least one regional center director and supervisor found the DMH Forensic Director and Director of Children's Mental Health to be very supportive and helpful to the center.

Waiting Lists

Leadership, staff, providers and consumers/families discussed several issues in regard to waiting lists. There was anxiety expressed that MRDD, and DMH more globally, has become a Medicaid-only system – if an individual is not eligible for Medicaid, that person will not receive services and may languish on the waiting list. It was stated frequently that individuals and families on the waiting list must go into crisis and then services may be approved. There was a great deal of frustration expressed about this, explaining that some temporary or interim type of service might avoid a crisis and the ensuing disruptions for families and consumers. Some leaders and staff indicated that, in the past, there had been discretionary funds or at least more flexibility in use of funds to allow limited services or one-time types of services to those waiting. Some reported having a small "budget" for service coordination teams and those teams had the discretion to use the funds for needs that arose. This was shared in the context of

individuals already receiving services but staff indicated this would also be helpful to address waiting list needs.

UR process

The UR process had mixed reviews. There were groups that saw it as an opportunity to be more consistent in decisions surrounding needs and services. Others saw the process as intimidating and sometimes misleading, in addition to just more paperwork. It was reported in some regions that applicants are told not to sign up with the regional center as there is no money; and that service coordinators are saying "no" to service requests in anticipation of the UR result. Crisis situations may increase the UR score for someone on the waiting list, but that is not seen as a preferred way to access services, as described above. There is also a perception in at least three regional center areas that UR decisions may be adjusted and the waiting list "jumped" because of phone calls to central office, legislators, and those otherwise well-connected. This undermines the UR process.

Eligibility

There were discussions about revisiting eligibility criteria and tightening up the system. As it is now, various populations are eligible for services for which we really don't have supports; or we need to develop the resources to provide those supports. Several individuals commented that MRDD should mirror more closely the federal definitions. Since the system has now evolved to be only a Medicaid system, the emphasis seems to be on making someone eligible for Medicaid programs, not truly assessing needs.

Rate Structure

Providers and center staff expressed dissatisfaction with the current rate structure. Providers indicated that rate increases were few and far between, when costs continue to rise. Rates vary significantly across the state and the rationale for the rates may not always be apparent or known. (See Appendix 5) Providers that have been in the system a number of years may be paid less than new providers entering the system for what is perceived as the same service. There is also a perception of disparity based on size—smaller providers being paid less that the larger providers. In some areas of the state, staff were concerned that smaller providers are having difficulty staying financially solvent and may have to close. Groups also recognized, however, that many factors are and should be considered when setting rates and there is likely to be some variability; for example, geographically, for special expertise serving medically or behaviorally challenging individuals, and other factors.

Staffing and Resources

Workload and Caseload Sizes

Service Coordinator (SC) caseload sizes range widely across the state – the lowest being about 1:40 and the highest about 1:72. These caseloads can increase based on turnover and vacant SC positions at any given time. Assignment of caseloads varies among the regional centers; some weight the caseloads, others have specialized population and/or specialized service caseloads and others have mixed caseloads. Travel distance and time in the rural areas contributes to the difficulty of managing large caseloads. SC supervisors were assigned a range of 8 to 22 SC. Large caseloads are compounded by growing monitoring and documentation requirements; examples included service monitoring process and real-time logging for billing purposes, to name just two. This contributes to the general trend away from person-centeredness and contributes to fears of "missing something" or "making a wrong decision", adding stress levels and general job dissatisfaction among SC in particular, but not limited only to them. Although there was a good deal of satisfaction expressed about SC from families and providers, there were also multiple observations made about how valuable a "good" SC is and how devastating a "bad" one can be. Providers commented that there is not a way, or at least a consistent method, of resolving problems with SC and providing feedback for SC performance assessment. Larger providers in particular may have many SC assigned and find that there are inconsistencies in the information given by the SC and in the manner in which the SC interact.

Most of the Registered Nurses (RN) are members of the Quality Assurance (QA) teams. The RN caseloads vary among the centers; however, the caseloads are very high, and health monitoring, reviews and consultation cannot consistently be conducted as required. QA staff expressed many of the same frustrations. QA teams in some areas function as QA, crisis support and response, and trainers.

Overall, leaders and staff express being spread too thin with multiple tasks and responsibilities which put them into the position of managing the paperwork instead of focusing on the consumer. The amount and type of paperwork and other requirements has grown, yet there seems to be little evaluation of what tasks might be removed or revised in some way to assist in managing the workload.

Turnover and recruitment

SC turnover is a challenge in many parts of the state and the turnover may even vary by satellite offices within the same regional center. There were many comments from leaders, staff and providers about SC salaries and caseload sizes, comparing the regional centers with the SB40 Boards that conduct case management and identifying this as competition for staff. These SB40 Boards were reported as having caseloads ranging anywhere from 18 to 30 per case manager and acknowledged that salaries were higher at the boards. Comments were that there are staff who work to gain some experience, then leave for better pay and lower caseload somewhere else. Salaries and workload limit

recruitment of persons having the quality and experience needed for the positions. Also, the feeling of heightened vulnerability that was expressed in relationship to the abuse and neglect system, inconsistent training and the current climate of DMH has an effect on the ability to recruit and retain staff. There are staff who have longevity in the system as well, who stay in spite of the competition in the private sector, the workload and the climate. There is a need for assistance in creative methods of recruitment and finding ways to tap the right markets for good candidates for positions.

Those consumers, families and providers who have experienced frequent changes in their SC identified how difficult it is to maintain any kind of consistency and familiarity with the needs of the consumer; the changes are very disruptive.

Training

Orientation of SC varies significantly throughout the system. In some areas, the SC orientation consists of self-study, didactic and on the job orientation; others give a basic overview and immediately pair up the new employee with a more experienced SC; the new SC may be rotated among several other SC for their on the job training; and still other areas assign responsibility for training to the SC supervisor who uses his/her own methods. Staff and providers expressed a need for more consistency in orientation and questioned how the current lack of standardized orientation may affect turnover and retention, if new staff does not feel prepared for the responsibilities of the position.

The needs for staff training mirror the gaps in services in many instances. Specific areas identified as ongoing training needs were:

- information and skills for working with those dually diagnosed MR/MI;
- tools and skills for working with individuals with behavior problems;
- implementation and application of positive behavioral supports;
- information about various disabilities, build on the basics;
- person-centered philosophy and how to carry that into practice;
- best practices in working with the developmentally disabled;
- autism spectrum;
- working with the aging DD population;
- supporting the medically and physically challenging consumer;
- practical application of writing personal plans;
- working with the forensic DD consumer and, in particular, sexual offenders;
- crisis intervention and management; and
- identifying, accessing and communicating resources - local, state and/or national.

In at least two of the regional center areas, staff expressed an interest in networking and training opportunities that would bring people together from many or all regional centers. They felt this would promote the ability to meet and exchange ideas, resources and experiences

Management and supervisory training were also identified as a need. There were concerns over a perceived lack of succession planning for these positions. There was interest in providing an opportunity to motivated staff who may be interested in moving into management positions to learn and to be mentored.

Needs for specialty expertise

Staff and providers identified a need for staff with specialty expertise. These mirror the gaps in services in many instances, and include the areas of:

- behavior specialist;
- children's behavior specialist;
- crisis intervention and support;
- dual diagnosis (MI/MR) expert;
- autism; and
- forensics.

Loss of supports and resources

Throughout the last several years of budget adjustments, consolidations were attempted and staff was lost through attrition, lay-off, and the restrictions on replacement of retirees in some circumstances. There are comments about the consolidation of leadership of the regional centers in the Leadership and Culture section. Other positions lost at various regional centers include support staff, accounting and business office staff, QA, supervisors and trainers. The mix and number of positions varied among the regional centers; however, the result universally has been that the workload of those no longer employed was absorbed by the staff that remained in the respective areas. The domino effect is that this impacts all along the organizational structure as well; for instance, some teams no longer have support staff, so SC spend more time on typing plans and other traditionally support duties, leaving less time for service coordination visits, arranging resources, and monitoring. In some areas, the staff that would recruit and develop providers to meet demands for services was either eliminated or became a shared position between two regional centers. QA teams in some areas absorbed crisis support and training.

Technology and equipment

Consistently across the state, concerns were expressed about the need for updated technology, particularly for staff in the field. SC spend much of the time in the field, traveling and visiting consumers, families and providers; yet they have desktop computers that tie them to the office for documentation, logging and other functions. There are limited numbers of laptops at some regional centers for staff to check out but there are issues with numbers and the practice is not universal across the centers. Staff and leaders thought that providing laptops at least for field staff would increase efficiency and productivity, as well as simply make the job easier.

A lack of cell phones slows staff response to calls and limits general accessibility when in the field. Many staff report using their own cell phones for business while traveling. Staff does not get reimbursed for the time/minutes used. People feel stymied in their ability to address this due to the difficulty of the process to obtain cell phones and the decisions made at a higher state level to limit the number and use of state cell phones. There are also pockets where voice mail is not available in offices.

Another issue is the regional center cars. Cars are beginning to show their age, require more maintenance and are high mileage. There are requirements for a minimum number of miles driven in order to keep a state car. Some regional centers have set up schedules for "rotating" the cars among satellite offices to try to meet this minimum; yet staff is in the field and needs transportation. Many staff reported that they use their own cars and often do not request mileage reimbursement because it is difficult to obtain such approval.

RECOMMENDATIONS

This review was conducted at a time when the Missouri Department of Mental Health was undergoing considerable scrutiny regarding several extensively publicized abuse & neglect cases. While the review was not focused specifically on abuse and neglect concerns, its timing guaranteed considerable feedback regarding these issues. Even so, no consensus developed regarding recommendations specific to the Department's handling of such cases.

Instead, the broad consensus that has emerged is that too narrow of a focus on safety and compliance issues is ultimately self defeating – even in terms of consumer safety the need is to balance compliance priorities with broader habilitation and quality enhancement goals and to keep all of it firmly in the context of a consumer first orientation. We need to balance compliance concerns and quality enhancement activities, but have recently tended to emphasize the former at the expense of the latter. The consensus recommendations below should be seen as strategies for restoring that necessary balance:

- Identify the vision, priorities, role, and function of the MRDD system, including the role of Central Office, the Regional Centers, and roles/expectations of providers; clearly communicate that to leadership, staff, providers, and consumers and their families. Build on this to define the structure to facilitate meeting the roles, functions and priorities—including, but not limited to: staffing patterns, expertise, configuration and relationship of RC to CO, size and number of Regional Centers, and utilization of resources. This may provide opportunity for redirection of positions and/or funds but can otherwise be done within existing resources.

- Establish standardized staffing patterns for the Regional Centers, based on appropriate caseload measures. The highest priority positions in this regard are the Service Coordinators and Registered Nurses, but staffing standards should be set once the Regional Center roles have been clarified. The short term recommendation is to gain additional funding to get Service Coordinator caseloads down to no higher than a 50:1 average at each Regional Center, while working with interested SB40 Boards to increase their service coordination capacity to the point of establishing 40:1 as the standard average caseload for each region. This recommendation will require additional funding and a budget request has been submitted.

- Review the Division's QA Directives and revise them to eliminate overlaps, standardize the review processes, and re-emphasize quality enhancement as a priority. A task force including staff involved first hand in the review processes should be utilized as part of this standardization. A longer term component of this recommendation is to begin piloting QA processes in partnership with accredited providers, using their own Quality Management reporting data as input and with Regional Center staff performing periodic validation reviews. These pilot projects are to provide valuable input to the accreditation recommendation below. This recommendation can be done within existing resources, since the staffing costs and accreditation costs are assumed within other items.

- Pursue accreditation of residential providers as a long term enhancement of our QA and certification procedures. Whichever accreditation body is selected as a standard for the division, providers previously accredited via equivalent standards should be grandfathered as in compliance with this strategy. To the extent that this will release certification staff from scheduled survey duties they should be redirected towards unscheduled (random and for cause) safety reviews. We estimate that full implementation of this strategy will be a three year project, and will require additional funding by the second or third year, and ongoing funding beyond the third year. Consideration of accreditation possibilities beyond residential services should be delayed pending evaluation of the impact on the quality and safety of residential services.

- Verify the gaps in service identified by the staff, consumers and families, and providers who participated in the review. Although some gaps were mentioned statewide, others are regional or the priority of the gap may vary by region. Promote participation of local providers in development or expansion of services to address the gaps. This is currently being done to address crisis intervention services.

- Develop relationship with psychiatric services and providers at both the central office and the local level. Promote partnerships that link the two systems.

- Assess the effectiveness and consistency of the Utilization Review process. Evaluate the individuals on the waiting lists periodically for changes in status/need. The goal has been set to eliminate one-third of the waiting lists and a budget request has been submitted.

- Examine the definitions of services and current rates for those services; establish uniform rates for those services, adjusting inequities over time.

- Address staff turnover at the Regional Center level, identifying strategies for retention of staff as well as effective recruitment methods. Work with Human Resources to assess current salary for classifications with high turnover compared with the market. Assess the feasibility of contracting for some functions currently being done by employees.

- Identify the overall needs for orientation and continuing education, and develop an education plan to address those needs. Regional Centers can then supplement that plan with needs specific to the individual area or plan jointly for needs in common with other regions, but not necessarily state-wide. The plan would be reviewed annually for accomplishments and any needed revision.

- Establish a core orientation curriculum for service coordinators, consistent and standardized. Consider bringing groups of new service coordinators to a central area for the training. Include methods of mentoring and supervision during the orientation period.

- Promote training and mentoring for current management staff, supervisory staff, and individuals whose skills and goals may make them good candidates for future leadership positions. Identify those areas where joint efforts and sharing of resources with community providers are feasible.

- Participation in the development and pilot of the College of Direct Support is an important and innovative project to address the needs of front line staff in the community.

- Explore resources internally, with other Divisions and with providers to identify those that have the specialty expertise to address identified needs. Relationship building with colleges/universities may assist in finding the personnel with the specialty expertise needed. Consider contracting for some of these areas where feasible; two areas where this concept is in process are crisis intervention and behavior analysis.

- Develop relationships with college and universities to increase awareness and interest in working with the MRDD population and presenting public service in a positive light. This is a potential untapped resource for many of the issues identified in this report.

Appendix 1
Regional Center "Demographics" (March 2006 consumer data)

Regional Center	# Consumers (Residential)	# Consumers (In Home)	Waiting List (residential)	Waiting List (In home)	# Counties	# SB 40 Boards	# SB 40S that do CM	# Agencies in Region w/ MRDD L /C	# Accredited
Albany	307	158	11	105	12	5	1	18	1
Central Missouri	691	344	34	67	13	11	4	61	8
Hannibal	414	156	29	74	8	7	2	30	6
Joplin	347	219	8	30	11	4	1	13	5
Kansas City	1173	637	119	942	8	8	1	90	17
Kirksville	157	205	7	81	14	5	?	10	2
Poplar Bluff	273	196	12	162	10	4	0	31	1
Rolla	364	260	4	37	14	13	4	36	5
Sikeston	231	125	6	124	9	6	0	16	0
Springfield	357	350	72	235	12	8	1	21	3
St Louis	1211	1207	130	1341	4	4	3	61	10
All RC combined	5525	3857	432	3198	115	75	8		

Appendix 2
Abuse and Neglect Cases for July 1 2005 – June 30 2006

Regional Center	# Abuse/Neglect Investigations	# Investigations pending (as of 8/04/2006)	% of Investigations pending (as of 8/04/2006)	# Determinations of Abuse or Neglect (as of 8/04/2006)	% of Completed Investigations resulting in A/N Determination
Albany	92	41	45%	33	65%
Central Missouri	42	9	21%	19	58%
Hannibal	40	15	38%	12	48%
Joplin	56	17	30%	20	51%
Kansas City	167	59	35%	51	47%
Kirksville	32	8	25%	14	58%
Poplar Bluff	20	8	40%	9	75%
Rolla	24	11	46%	6	46%
Sikeston	41	16	39%	12	48%
Springfield	87	27	31%	31	52%
St Louis	166	76	46%	35	39%
All RC combined	767	287	37%	242	50%

Appendix 3
Integrated QA Functions Implementation

Regional Center	Service Monitoring	Health Inventory	Death Review	Incident Response CEF	Incident Response iiTS	Complaint Response	Personal Plan Reviews	Fiscal Review - funds	Fiscal Review - services
Albany	YES	YES	YES	YES	YES	YES	Partial	YES	Partial
Central Missouri	YES	YES	YES	YES	YES	YES	Partial	Partial	YES
Hannibal	YES	YES	YES	YES	YES	YES	NO	Partial	Partial
Joplin	YES	YES	YES	YES	YES	YES	NO	NO	NO
Kansas City	YES	Partial	YES	YES	YES	Partial	NO	Partial	Partial
Kirksville	YES	YES	YES	YES	YES	YES	NO	Partial	Partial
Poplar Bluff	YES	Partial	YES	Partial	YES	YES	NO	YES	YES
Rolla	YES	Partial	YES	YES	YES	YES	Partial	YES	YES
Sikeston	YES	YES	YES	Partial	YES	YES	Partial	YES	? (not reviewed)
Springfield	YES	Partial	YES	YES	YES	YES	Partial	NO	NO
St Louis	YES	Partial	YES	Partial	YES	YES	Partial	YES	Partial

"YES" does not mean without issues & concerns -- as outlined in report there are similar issues across the state when a given function is implemented. This aims to reflect that, warts and all, a function is implemented.
"Partial" means implemented but with significant backlog
"NO" means either not started or training only or very early implementation that is too inconsistent to call partial.

Appendix 4
Staffing Ratios and Turnover

Regional Center	Average SC Caseload	Average RN Caseload*	RN Staffing	QA Staffing	Turnover – SC~
Albany	1:40	1:309	1	3	16%
Central MO	1:40	1:350	2	8**	10%
Hannibal	1:50-55	1:405	1	5**	0%^
Joplin	1:59	1:347	1	3	15%
Kansas City	1:60-70	1:587	2	6.5	18%
Kirksville	1:40	1:147	1	3**	35%
Poplar Bluff	1:50	1:192	1	3	0%
Rolla	1:40	1:308	1	5**	24%
Sikeston	1:60-70	1:118	2	3	20%
Springfield	1:50-55	1:353	1	2	11%
St. Louis	1:50-60	1:325	4	6	22%

*RN/Consumer ratio based on consumers in placement, not total consumers nor consumers in RCF I or II, ICR/MR or SNF; RNs are on the QA teams but were not included in the QA staffing
**Quality Assurance staff also have responsibilities other than QA
^HRC had four service coordinators leave about the time of the RC System Reviews
~Based on FY 06 3rd quarter, annualized

Appendix 5
Residential Habilitation and ISL rates
(Rates as of March 2006; rates do not include room and board costs)

REGIONAL CENTER	RESIDENTIAL HABILITATION			INDIVIDUALIZED SUPPORTED LIVING		
	Minimum	Average	Maximum	Minimum	Average	Maximum
Albany	$46.36	$138.87	$321.82	$49.66	$179.72	$394.45
Central MO	$62.28	$133.48	$321.82	$18.14	$136.51	$460.68
Hannibal	$53.29	$116.67	$455.42	$40.81	$161.81	$315.09
Joplin	$54.06	$110.41	$152.75	$41.48	$163.06	$384.13
Kansas City	$36.20	$117.62	$427.36	$25.96	$165.54	$721.74
Kirksville	$72.07	$126.75	$226.85	$49.44	$165.10	$461.04
Poplar Bluff	$53.45	$87.41	$156.15	$39.45	$164.92	$363.71
Rolla	$45.97	$113.88	$156.15	$17.23	$125.21	$472.08
Sikeston	$40.58	$98.82	$200.85	$15.48	$140.10	$299.90
Springfield	$62.34	$109.76	$169.19	$36.96	$171.48	$352.25
St. Louis	$57.62	$155.57	$301.54	$29.98	$194.92	$664.83